Washington State Office of the Insurance Commissioner

Office of the Insurance Commissioner

ESSB 5940

**K–12 School District Employee Health Benefits
Data Collection Project**

Year 2 Data Call Instructions — Carriers

Contract   PS 2013.18

Description: Instructions for Year 2 ESSB 5940 Data Call — Carriers

Contents

Overview

This document provides instructions concerning the carrier Year 2 Data Call authorized by ESSB 5940 ('the legislation') which directs the Office of the Insurance Commissioner (OIC) to collect data from K-12 carriers. Treinen Associates[1] is collecting the data on behalf of the OIC. The legislation requires reporting of K–12 school districts' health benefits, demographics, and financial data for district health plans[2] only. However, carriers may include any vision exam benefit or cost embedded in the reported medical plans.

For 2013, <u>districts</u> will be required to report dental and vision total premiums paid during the plan year; however, dental and vision data is <u>*not*</u> part of the <u>carrier</u> Data Call.

Data should <u>*not*</u> include information for Educational Service District (ESD) employees, retirees, or COBRA participants.

Submission Process and Confirmations

Please acknowledge[3] receipt of the Data Call to the commissioner's mailbox 5940survey@oic.wa.gov . The acknowledgement must include the contact person's name, e-mail address, and telephone number. Also, send an acknowledgement to Y2DataCallTeam@Treinen.com. In addition, each carrier must submit a statement of validity (posted on the commissioner's website) with its submission[4].

Following your initial submission, there will be only one opportunity for resubmission[5], which does not include correcting data files with submission errors. The resubmission is required within 30 days of notice to resubmit.

To submit data, or revisions to any carrier data, carriers must use ShareFile, a custom-branded password-protected application where carriers will be able to exchange files and submissions securely. Do not password-protect or encrypt your spreadsheet or the Treinen team will not be able to process it.

All communications between ShareFile and each carrier will use this e-mail: Y2DataCallTeam@Treinen.com. Send all submissions to ShareFile directly. Send all correspondence in Year 2 to Peggy Reddy. (Peggy@TreinenAssociates.com) and copy Y2DataCallTeam@Treinen.com. Please discontinue use of the Year 1 e-mail address.

When a carrier submits data, the project team will automatically validate and process the data using an application built for this purpose. The sequence for acceptance or rejection of data submissions and steps for required corrections follows:

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[1] Treinen Associates and its contractors

[2] See Health Plan definition under RCW 48.43.005 (26). Carriers must report plan design cost-sharing provisions for each plan for each plan year offered; report monthly premium rates by plan; and report other financial data including premiums, paid claims, and demographics information by "Benefit Package". A Benefit Package is one health plan, or an aggregation of health plans. Please refer to Section 5.

[3] Acknowledgement is required pursuant to WAC 284-198-010 and pursuant to WAC 284-198-050.

[4] Pursuant to WAC 284-109-035

[5] Pursuant to WAC 284-198-030

1) Each ShareFile user will receive an e-mail stating that your data has been accepted or rejected. If rejected, your ShareFile account will receive the rejected data file with the errors and or warnings noted. You are then required to log into ShareFile, retrieve the 'return file', and make corrections.

2) When the carrier retrieves the return file, ShareFile automatically sends an e-mail to the Treinen project team informing them that the carrier has downloaded their respective file.

3) Once the carrier makes corrections to the Data Collection Spreadsheet, the carrier uploads the corrected data file to ShareFile. Before uploading your data, please rename the file according to the version-naming convention described below.

4) The cycle continues until the data within the Data Collection Spreadsheet is accepted. Each carrier will receive an e-mail upon acceptance of the carrier's Data Collection Spreadsheet file.

Important Notice

Individual users may add or delete other ShareFile contacts within their organization.

All users within a given carrier have exactly the same profile in terms of access rights and user privileges.

ShareFile will send all communications to all carrier contacts provided to Treinen (although individual users may change their notification settings).

Any carrier contact can log onto their organization's ShareFile account in order to upload or download data.

If you encounter difficulties configuring or using ShareFile, or have questions about it, please send an e-mail to Peggy Reddy at Peggy@TreinenAssociates.com and copy Y2DataCallTeam@Treinen.com.

Template Files and Data Submission Format

These instructions include template files in CSV format as part of this Data Call. Save or import the CSV file to the XLSM Data Collection Spreadsheet format. Please submit carrier data in a single XLSM spreadsheet matching the XLSM template provided with these instructions. The file includes twelve separate tabs; the first is the instructions tab and the remaining are associated with the 11 Sections of the Data Call.

Data File Naming Convention

When saving the Excel spreadsheet that contains your carrier's data, please use the following naming convention: **Carrier-V*nn*.xlsm** where:

Carrier   is a shortened version of the carrier name

nn   is the version (reflecting the number of times you have previously submitted data); the first time you submit data, please use V01 and then increment the version number V02, V03, V04 etc. with each of any subsequent resubmissions.

Section Overview

The data request has eleven sections. These sections represent individual sheets in the spreadsheet. We describe each section in detail later in this document.

Section 1	Carrier Annual Reporting — For Calendar Year 2013
Section 2	Innovative Health Plan Features (For all K–12 Plans Combined in 2013)
Section 3	Reserves by Rating Pool (Ending Reserves)
Section 4	Health Plan-Year Information (All Plan Years in 2013)
Section 5	Benefit Package Performance — For Plan Years Ending in 2013
Section 6	Benefit Package Performance by Month
Section 7	Benefit Package Demographics — Plan Years Ending in 2013
Section 8	Plan Code Rates and Enrollments by District — Plan Years Ending in 2013
Section 9	Large Claims — For Plan Years Ending in 2013
Section 10	Plan Cost-Share Designs — All Plan Years in 2013
Section 11	Plan Rates — All Plans Offered in 2013

Required Values and Formats

1. Please do not alter column headings. If you do so, the data you submit will not load to the database and you will have to resubmit it.
2. All fields are required in all sections, except where this document notes otherwise. Leave status columns blank. If the project team returns the data due to errors, the status columns will contain values showing errors or warnings for the appropriate rows.
3. Field Formats:
   a. Text, followed by maximum size. If no size is specified, the field can support pages of text (limited for reporting representation only)
   b. Integer (whole number, no decimals)
   c. Date — MM/DD/YYYY format (for example, 09/30/2013)
   d. Decimal (with number of places to the right of decimal specified)
   e. Currency (two decimal places to right of decimal)
4. Enter 0 for numeric totals with zero values, or not applicable, "N/A", for text fields

Year 2 Changes
Changes to the data call in Year 2 follow.

Instructions for Year 2 ESSB 5940 Data Call — Carriers

Section	Changes Only
Instructions	• Added **Check My Spreadsheet** button to the data template spreadsheet.
1	• Replaced **Signed_By** field with **Submitted_By** field. • Replaced **Date_Signed** with **Submitted_Date** field. • Added **Submitted_Email**. • Added **SpreadSheet_Check_Date**.
4	• Removed **Desc_CostShares**. • Removed **Desc_PremiumRates**. • Added **Plan_Type**, column G, other fields shifted right. • Added **CostShare_Code**, column L, other fields shifted right.
5	• Removed **Emp_Enrollment**. • Removed **Dep_Enrollment**. • Removed **Total_Premiums**. • Removed **Total_MedPremiums**. • Removed **Exp_Claims**. • Removed **Inpatient Claims**. • Removed **Outpatient_Claims**. • Removed **Outpatient_ER_Claims**. • Removed **Professional_Claims**. • Removed **OtherMed_Claims**. • Removed **Pharmacy_Claims**. • Removed **OtherMed_P**. • **Capitation_Payments** moved from column U to column J.
7	• **PY_Ending** moved from column O to column C, other fields shifted right.
8	Removed **BP_Code**. Removed **EE_Rate**. Removed **ES_Rate**. Removed **EC_Rate**. Removed **EF_Rate**. Removed **OD_Rate**. Replaced **Rate_Desc** with **RateSet_Code**. **Plan_Code** moved from column J to column B. **PY_Ending** moved from column I to column C.
10	New section added for cost-share designs.
11	New section added to store plan rates.

Validations Across Sections

Please review carefully and make note of validations of code values and balances between sections:

1. Section 3 pool codes are unique and match pool codes referenced in Section 4.
2. Section 4 plan codes are unique for a given period.
3. Section 4 benefit package codes, which aggregate reporting of plans in Sections 5, 6, 7, and 8, are unique for a given period and are included for all plans. Benefit package aggregations of plans follow rules that allow aggregating of plans with low enrollment or plans with similar actuarial values, for plans with the same plan periods in both cases.
4. Sections 5, 6, 7, and 8 include all benefit packages listed in Section 4 with the plan year ending in the current year. Total premiums, enrollments, and claims for each benefit package should be approximately the same across sections.
5. Section 6 includes the validations in the preceding sections and it includes those with a plan year ending in the next year.
6. Section 8 plan codes and periods match Section 4, district-county codes match OSPI lists, and validate that premium rates for all districts with enrollments separately for each group within the district.
7. Section 10 cost-share design codes are unique and match those referenced in Section 4.
8. Section 11 plan rate-set codes are unique and match those referenced in Section 8.

Section 1 — Carrier Annual Reporting — For Calendar Year 2013

This Section requests information by carrier with regard to health benefit plans offered to K–12 school districts within the State of Washington. Each carrier is requested to describe in the respective areas (fields below) its progress, efforts, and achievements during the calendar year 2013. Describe overall strategies towards healthcare cost savings, reduced administrative costs and unnecessary health services, and improved management of K–12 health programs.

Col	Column Name	Column Definition
A	Field_Name	From the field name below
B	Status	Status column (leave blank)
C	Carrier_Response	Carrier responses will be entered into this column
D	Field_Desc	Description from below

Row #	Column A Field Name	Description	Format
1		The first row has the column headings	Do not change
2	Carrier_Name	Carrier Name	Text 60
3	PR_Beginning	Beginning date of performance reporting. Earliest beginning date for any plan year ending in 2013	Date
4	PR_Ending	Ending date of performance reporting, or calendar year ending in 2013	Date
5	Desc_CostSavings	Describe efforts and achievements toward healthcare cost savings	Text
6	Desc_ReduceAdmin	Describe efforts and achievements toward significantly reducing administrative costs	Text
7	Desc_Innovations	Describe other innovations designed to reduce health-benefit premium growth and to reduce the use of unnecessary health services. The next section lists a separate check-off list of specific innovations. This narrative can capture any comments or other innovations not listed in the next section.	Text (optional)
8	Desc_DistrictManage	Describe efforts and achievements to help districts to manage their health benefit programs	Text
9	Desc_DistrictProcure	Describe what information is needed for districts to procure health insurance with your company	Text
10	Desc_CustService	Describe efforts and achievements to improve customer service	Text
11	Desc_ProtectPT	Describe efforts and achievements to protect access to coverage for part-time employees	Text
12	Submitted_By	The name of the person submitting the data	Text 80
13	Submitted_Email	E-mail to whom to send responses	Text 80
14	Submitted_Date	Date of data submission	Date
15	SpreadSheet_Check_Date	System generated date of the last time "Check-My-Spreadsheet" was run	Date

Section 2 — Innovative Health Plan Features (For all K–12 Plans Combined in 2013)

Identify innovations available or offered to districts (across all plans offered to districts) from a pre-defined list. Enter "Y" if the feature is available in any plan offered to K–12 school districts in Washington during the calendar year 2013 (this can include prior or current plan years, which overlap calendar 2013). Enter "N" or leave the field blank if the feature is not used, including those times when it is available elsewhere, but not offered to the districts. Entries begin in row two, column B.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Used_YN	Is innovation used or offered (Y or N/blank)	Text 1
C	Innov_No	Number for the innovation (1–24 do not change)	Numeric 1–24
D	Innov_Desc	Description from below (do not change)	Text 200

Innovative Health Plan Features — Survey for Carriers

1   PPO network
2   Centers of excellence for high-cost cases
3   Value-based plan designs
4   Case management; utilization management program
5   High-risk maternity program; maternity education program
6   Assessment of chronic diseases in a given population
7   Focused disease management program
8   Wellness program design and resources
9   Health-risk assessments
10 Coverage for treatment of obesity
11 Coverage for smoking cessation
12 Assessment of health risks within the district population
13 Reports to district on health-plan performance
14 Communication programs to support healthy behaviors
15 Information on medical trends and factors contributing to increasing claim trends within district populations (for example, high-cost cases, utilization of ER services, and hospital admissions)
16 Provide district clients with healthcare cost trends
17 District-specific claims data
18 Membership-specific feedback to plan participants/members on necessary medical services
19 Nurse line services
20 Website health tools and resources
21 Assessment of targeted chronic conditions, such as diabetes and depression, in the district population
22 Wellness newsletters and/or wellness messages on carrier website
23 Three-tier prescription drug program (generic, preferred brand, and non-preferred brand)
24 Four-tier prescription drug program (generic, preferred brand, non-preferred brand, and specialty)

Section 3 — Reserves by Rating Pool (Ending Reserves)

Report K–12 health plan reserves ending balances as of the plan year ending in 2013 — at the purchasing or rating pool level. Include K–12 health-plan reserves held by the carrier, trust, or other third-party pool. Include paid claims and enrolled employees and members by applicable rating or purchasing pool for the plan year ending in 2013. Do not include any non-K–12 health reserves. A code identifier identifies each pool, which Section 4 uses to link plans to applicable pools.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Pool_Code	Create a unique pool identifier to identify the plans covered by this reserve	Text 20
C	IBNR_Reserves	Plan-year-ending balance — Incurred but not reported (IBNR) reserve amount	Currency
D	Rate_Reserves	Plan-year-ending premium/rate-stabilization reserve amount, if one exists	Currency
E	Total_Claims	Plan-year total paid claims by applicable rating pool	Currency
F	Covered_Employees	Plan-year 2013 covered employees by rating pool	Integer
G	Covered_Members	Plan-year 2013 covered members by rating pool (members = employees plus dependents)	Integer

Notes on computations:

- Compute covered employees and covered members using either counts at the plan-year end, or average enrollments over the entire plan period. Average enrollment = the sum of monthly enrollments divided by the number of months in the plan year.
- You may associate a pool identified here with one or more plans in Section 4, but only associate each plan in Section 4 with one pool.

Section 4 — Health Plan-Year Information (All Plan Years in 2013)

List one record for each health-plan design offered in the 2013 calendar year. List each plan-year period separately, but use the same plan code for each record with the same plan/cost-share design. In other words, if the same plan design spans multiple periods, use the same plan code for each record regardless of the period. If the cost-share design for a plan changes, assign a new plan code to that plan. We recommend adding a suffix to the original plan code to indicate that it is a related plan that changed cost-share design from one period to the next.

Multiple plans can have the same cost-share design; for example:

Plan	Cost-Share Design
A	X
B	Y
C	X
D	Z

A carrier might offer Plan A to district one and Plan C to district two. The rates may be different, but the cost-share design is the same. Carriers can share the same cost-share design, although this will not be common.

Include plan design information in the narratives below. Include all plans beginning or ending in 2013 (if a plan ends before 2013 or starts after 2013, it should be excluded).

For plans that follow the calendar year, list each plan once per cost-share level. For plans which span multiple calendar years, list each plan period which covers a portion of calendar-year 2013 separately (for example, 2012 – 2013 and 2013 – 2014 are listed separately). Do not include plans which end prior to or begin after 2013. Do not include plans that do not include a portion of the 2013 calendar year.

Year 2 notes — Plans and benefit package codes used in the Year 1 submission for 2012 – 2013 plans must be consistent with the Year 1 submissions. Do not change the plan codes or benefit package codes. For a plan design continuing into the next year, use the same benefit package code. Aggregation of plans should not change, unless the plan design changes.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Plan_Name	Health benefit plan name	Text 60

Col	Column Name	Column Definition	Format
C	Plan_Code	Plan identifier. List one record for each plan/cost-share design/plan year. Each plan code/period combination must be unique. The same code for a different period indicates the same plan design continues into the next period. Section 8 references plan codes for reporting district enrollments by plan.	Text 20
D	BP_Code	Benefit Package (BP) identifier. The project team uses this value to associate a plan design reported here with the reporting of the plan's performance data in Sections 5, 6, and 7. There should be one BP Code for each plan code, with some exceptions. You may aggregate plans with less than 200 employees into a BP Code. If the aggregation of these "small" plans does not produce 200 employees or more in total, one may add a "large" plan to the BP aggregation to bring the total employees to 200 or more. "Large" plans are those plans with 200 or more employees. Do not aggregate two or more large plans. You may also aggregate plans with similar actuarial values. We recommend that the plans have, at a minimum level of similarity, the same "metal" level. Metal levels are platinum, gold, silver, and bronze, as defined in the ACA. Do not change BP Codes for plans and aggregations used for Year 1 data. Apply the above rules only to plans new to Year 2 data that have new plan codes. Apply BP aggregations consistently in Sections 5, 6, and 7. See the Section 5 for more details on reporting performance in a BP aggregation.	Text 20
E	Pool_Code	Pool code from Section 3 used to identify reserves used for this plan.	Text 20
F	HDHP_YN	Is this a high-deductible health plan?	Y or N

Col	Column Name	Column Definition	Format
G	Plan_Type	Choose a Plan Type code from this list: • HMO – licensed as an HMO • PPO – In-network and out-of-network benefits, includes POS and "Open Access" HMO plans • Closed Network – Similar to HMO with in-network only benefits • In-Network – same as Closed Network	Text 20
H	PY_Beginning	Plan-year-beginning date	Date
I	PY_Ending	Plan-year-ending date	Date
J	Desc_CoveredBenefits	Plan summaries are not required for Year 2. Complete Section 10 and provide appropriate plan design information including deductible levels, co-insurance, copays, and other cost-share features. The CostShare_Code in Section 10 should match the CostShare_Code in this Section 4.	Leave this field blank
K	Desc_Supplemental	Describe separate supplemental services offered that are not built into premiums. These include programs that are not part of the medical plan billed separately. Examples include wellness programs, weight management programs, and others.	Text
L	CostShare_Code	Cost-share Code for this plan design. Section 10 specifies cost-share codes and identifies deductible levels, co-insurance, copays, and other cost-share features.	Text 20
M	Plan_Act_Value	Plan actuarial value (0.00 – 1.00), as published in the federal regulations implementing the Affordable Care Act[6].	Value between 0.00 - 1.00
N	Ded_FollowCalendar	Deductibles reset on calendar year	Y or N

Below is an example that lists plan codes, plan periods, actuarial values, benefit package codes, and a note indicating in which subsequent sections to list that benefit package for the stated plan-year-ending date.

Row	Plan Code	Plan Year Beginning and Ending	Actuarial Value	BP Code	BP Plan-Year-Ending Date is Included in Following Sections
A	Plan1-200	10/1/2012 – 9/30/2013	0.90	BP1	9/30/2013 in Sections 5, 6, 7, 8
B	Plan1-200	10/1/2013 – 9/30/2014	0.90	BP1	9/30/2014 in Sections 6 and 8
C	Plan2-500	10/1/2012 – 9/30/2013	0.85	BP2	9/30/2013 in Sections 5, 6, 7, 8
D	Plan2-500	10/1/2012 – 9/30/2014	0.85	BP2	9/30/2014 in Section 6 and 8
E	Plan3-200	9/30/2012 – 9/30/2013	0.90	BP1	Included in **A**
F	Plan3-200	10/1/2012 – 9/30/2014	0.90	BP1	Included in **B**
F	Plan4-250	1/1/2013 – 12/31/2013	0.90	BP3	12/31/2013 in Sections 5,6,7,8
G	Plan4-1000	1/1/2013 – 12/31/2013	0.77	BP4	12/31/2013 in Sections 5,6,7,8

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[6] The Minimum Value Calculator will return values as a decimal between 0.00 – 1.00 for each plan's actuarial value. A value of 1.00 would indicate that a plan covers 100% of expected medical expenses for an average population. A value of 0.90 would indicate that a plan covers 90% of expected medical expenses for an average population. Some individuals, in this example, might see more than 90% of their expenses covered, whereas others would see less.

The above example shows:

- Typical plan-year-beginning and ending periods
- Plan codes with different cost-share designs are listed using separate codes
- Plan1-200 and Plan3-200 are aggregated into BP1 for the given periods, PYE 9/30/2013 and PYE 9/30/2014
- BP codes do not combine plans with different actuarial values or mixed periods
- Plans that begin, but do not end, in 2013 are reported in Section 6 (monthly) and Section 8 (by district), but not in Section 5 (plan-year-ending) or Section 7 (demographics at plan-year-ending)

Section 8 will include each plan code and plan-year-ending combination with a breakdown of district enrollments by employee groups for the given plan, with premium rates shown separately for each group.

Once plans are included in a given benefit package, the aggregation should be consistent across sections. Total premiums/claims for each benefit package/period should be similar across sections. Annual enrollments also should be similar; that is, Section 6 shown by month and each month should be similar to the annual total, with monthly variations expected.

Section 5 — Benefit Package Performance — For Plan Years Ending in 2013

List the health plan (benefit package) performance for plan years ending in 2013. For school district plan years, this is typically 10/1/2012–9/30/2013. Performance data includes enrollment, premiums, and claims. Annual performance includes utilization, administration, supplemental fees, and other expenses. Report on performance for plan years ending in the calendar year 2013 only.

For plans with less than 200 employees, you may create benefit packages that are an aggregation of such smaller plans. You may also aggregate plans with similar actuarial values into a benefit package when reporting plan performance, including small and large plans. Report the aggregated plans as instructed below. Please report aggregated plans in Year 2 on the same basis as Year 1. Aggregated plans must have consistent plan-year-beginning and plan-year-ending dates.

You may calculate actuarial values according to publicly available tools such as the "Minimum Value Calculator" published in federal regulations implementing the Affordable Care Act. Plan aggregations must be consistent across all Sections. The same rules of consolidation by Benefit Package apply to performance reporting in Sections 6, 7, and 8; please apply the rules consistently across sections.

For non-aggregated plans, the Plan_Code and BP_Code will be the same.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	BP_Code	Benefit package code from Section 4	Text 20
C	PY_Ending[7]	Plan-year-ending date	Date
D	Total_Supplemental	Plan-year total fees for supplemental services	Currency
E	Exp_Comm	Plan-year total commissions paid	Currency
F	Exp_Taxes	Plan-year total taxes and WSHIP, or other assessments paid	Currency
G	Exp_PPO	Plan-year total Preferred Provider Organization access fees	Currency
H	Exp_Fees3rdP	Plan-year total fees paid to associations, trusts, and other third parties, including benefit administration and marketing-related compensation	Currency
I	Exp_OtherAdmin	Plan-year total carrier admin fees not reported above. This represents the carrier's administration expense component of premium[8].	Currency
J	Capitation_Payments	Plan-year total capitation payments	Currency

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[7] Use the plan-year-ending date for the plan associated with the benefit package code. If the benefit package code is an aggregate of plans, all of the plans in that aggregation should have the same plan-year-ending dates.
[8] This field cannot be zero. It is the carrier's component share of premiums or the carrier's administration fees, administration expense or retention. This represents the carrier's cost of doing business exclusive of taxes, PPO access fees, commissions or other payments to third parties.

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Col	Column Name	Column Definition	Format
K	Inpatient_AvgLOS	Plan-year inpatient-facility average lengths-of-stay. This should equal Inpatient_D/Inpatient_A Average length of stay (LOS) is not measured on a per 1,000 basis. It is the total inpatient days divided by the total admissions. Or total inpatient days per 1,000 divided by total admissions per 1,000. Either way the answer is the same.	Decimal 1[9]
L	Inpatient_A	Plan-year inpatient facility admits per 1,000 members	Decimal 3
M	Inpatient_D	Plan-year inpatient days per 1,000 members	Decimal 3
N	Outpatient_V	Plan-year outpatient facility visits per 1,000 members **without ER visits**	Decimal 3
O	Outpatient_ER_V	Plan-year outpatient **ER visits only** per 1,000 members	Decimal 3
P	Professional_V	Plan-year professional services visits per 1,000 members	Decimal 3
Q	OtherMed_V	Plan-year other medical visits per 1,000 members	Decimal 3
R	Pharmacy_GS	Plan-year pharmacy generic scripts (30-day fills) per 1,000 members	Decimal 3
S	Pharmacy_BS	Plan-year pharmacy brand scripts (30-day fills) per 1,000 members	Decimal 3

Notes on utilization computations:
1. Compute plan-year enrollments as either snapshot values at plan-year-ending, or average enrollments (average = total of monthly enrollments ÷ number of months).
2. Utilization columns L through S are per 1,000 members. A value of 1,000.000 = an average of one occurrence per member per plan year. Scripts are per 30-day fills. A value of 12,000.000 = an average of one script per member per month.
3. Prescriptions offered for longer than 30-day fills should be adjusted to correspond to 30-day fills as follows: Divide the number of days actually given by 30. So a 34-day fill would be reported as 1.133 prescriptions.
4. Prescriptions offered for less than 30-day fills should be reported as follows: Divide the number of days actually given by 30. So a 7-day fill would be reported as .233 prescriptions for 1 and .0467 for 2.
5. Compute and round utilization values to three places after the decimal.

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[9] Reduced to one decimal for the Year 2 data. It was two decimals for Year 1 data.

Section 6 — Benefit Package Performance by Month

You must report monthly data <u>for all months for plans with plan years ending in 2013,</u> and the <u>remaining months of 2013</u> for plans beginning in 2013 and continuing into 2014.

Please list each health plan (benefit package) with enrollment, premiums, and paid claims for each <u>calendar month</u> within the plan years starting or ending in 2013.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	BP_Code	Benefit package code from Section 4	Text 20
C	PY_Ending[10]	Plan-year-ending date	Date
D	Calendar_Month	The month of 2013 for which the data is applicable. Enter a value from 1 to 12 where 1 = January.	Integer
E	Emp_Enrollment	Enrolled employees headcount	Integer
F	Dep_Enrollment	Enrolled dependent headcount	Integer
G	Total_Premiums	Premiums	Currency
H	Total_MedPremiums	Medical portion of premiums; include Rx, exclude vision and dental	Currency
I	Total_Claims	Total claims	Currency
J	Inpatient_Claims	Inpatient facility claims	Currency
K	Outpatient_Claims	Outpatient facility claims without ER claims	Currency
L	Outpatient_ER_Claims	ER claims only	Currency
M	Professional_Claims	Professional services claims	Currency
N	OtherMed_Claims	Other medical claims	Currency
O	Pharmacy_Claims	Pharmacy claims	Currency

Notes/Examples:

1. For a plan beginning 10/1/2012 and ending 9/30/2013, and then continuing into 2014, report all 12 plan months (October 2012 through September 2013) for the plan year ending 9/30/2013, and the first three months of the plan year ending 9/30/2014 (October – December of 2013). Report 15 months of data.
2. For a plan beginning 1/1/2013 and ending 12/31/2013, report 12 months of data.
3. Do not include plans ending <u>before</u> calendar year 2013 or beginning <u>after</u> calendar year 2013. Report all data for calendar year 2013.

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[10] Use the plan-year-ending date for the plan associated with the benefit package code. If the benefit package code is an aggregate of plans, all of the plans in that aggregation should have the same plan-year-ending dates.

Section 7 — Benefit Package Demographics — Plan Years Ending in 2013

For each benefit package, report employee and dependent demographics by gender, age, and coverage tier, as required by the legislation. Base tier reporting of dependents on the coverage tier of the covered employee.

The demographic reporting record contains three indicators:

1. **Emp_Dep** indicator:
   a. **E** = Employee
   b. **D** = Dependent
2. **M_F** gender:
   a. **M** = Male
   b. **F** = Female
3. **Tier_Code** is one of five values:
   a. **EE** = Employee Only
   b. **ES** = Employee + Spouse
   c. **EC** = Employee + Child
   d. **EF** = Employee + Spouse + Child(ren)
   e. **OD** = Other Dependent.
4. For plans with additional tiers for multiple children — report using corresponding EC or EF tiers.

Each record holds 11 fields — each corresponding to an age bracket (documented below) to hold counts of members in the age bracket.

Detailed Processing Rules:

- For each employee, add 1 to the age bucket corresponding to the employee age, in the record Emp_Dep = E (Employee), M_F = the employee gender, and Tier_Code = the employee's coverage tier.
- For each employee dependent, add 1 to the age bucket corresponding to the dependent age, in the record Emp_Dep = D (Dependent), M_F = the dependent Gender, and Tier_Code = the corresponding employee's coverage tier. Tier "EE" should have no dependent record, and tier "OD" should have no employee records.
- A four-tier program design (without "OD") requires up to 14 records (EE-only tier has no male or female dependents). You may record a "0" for all ages, or omit the enrollment, for records with all counts equal to zero, or where selected tiers have no enrollments, or that you do not offer.
- The sum of all age counts in employee records and all age counts in dependent records should match reported head count totals by employee and dependents reported in the plan-year-ending data in Section 5, and in totals across all districts in Section 7.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	BP_Code	Benefit Package code from Section 4	Text 20
C	PY_Ending[11]	Plan-year-ending date	Date
D	Emp_Dep	**E** = Employee or **D** = Dependent	Text 1
E	M_F	**M** = Male or **F** = Female	Text 1
F	Tier_Code	Tier Code where **EE** = Employee Only, **ES** = Employee + Spouse, **EC** = Employee + Child, **EF** = Employee + Family or **OD** = Other Dependent	Text 2
G	Age_Tier1	Headcount Age band 0–19	Integer
H	Age_Tier2	Headcount Age band 20–24	Integer
I	Age_Tier3	Headcount Age band 25–29	Integer
J	Age_Tier4	Headcount Age band 30–34	Integer
K	Age_Tier5	Headcount Age band 35–39	Integer
L	Age_Tier6	Headcount Age band 40–44	Integer
M	Age_Tier7	Headcount Age band 45–49	Integer
N	Age_Tier8	Headcount Age band 50–54	Integer
O	Age_Tier9	Headcount Age band 55–59	Integer
P	Age_Tier10	Headcount Age band 60–64	Integer
Q	Age_Tier11	Headcount Age band 65+	Integer

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[11] Use the plan-year-ending date for the plan associated with the benefit package code. If the benefit package code is an aggregate of plans, all of the plans in that aggregation should have the same plan-year-ending dates.

Section 8 — Plan Code Rates and Enrollments <u>by District</u> — Plan Years Ending in 2013

For each health plan, this section requires reporting of information by each school district. Please list district total premiums for the twelve-month period plan year ending in 2013, and employee and dependent headcounts and rates at the end of the plan year. For districts with multiple groups of employees with different rates for the same plan, separate the enrollments and identify each group with a corresponding rate-set code, identified in Section 11 (plan rates).

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Plan_Code	Plan code from Section 4	Text 20
C	PY_Ending	Plan-year-ending date	Date
D	SD_Code	District county code from OSPI Lists[12]	Text 5
E	Emp_Count	Plan-year employee headcount	Integer
F	Dep_Count	Plan-year dependent headcount	Integer
G	Total_Premiums	Plan-year total premiums	Currency
H	Total_MedPremiums	Plan-year total medical portion of premiums	Currency
I	District_Name	District Name	Text 60
J	RateSet_Code	Code to match to the set of rates in Section 11	Text 20
K	RateSet_Desc	This describes to which employee group the rates tie	Text 40
L	EE_Count	Plan-year enrollment at EE Rate	Integer
M	ES_Count	Plan-year enrollment at ES Rate	Integer
N	EC_Count	Plan-year enrollment at EC Rate	Integer
O	EF_Count	Plan-year enrollment at EF Rate	Integer
P	OD_Count	Plan-year enrollment at OD Rate	Integer

Note: Section 8 column J is the Rate Set Code, which ties to the Rate Set Code in Section 11. It is the rate-set matching for the plan (and employee group) in Section 8. Section 8 may have multiple instances of a plan code if there are multiple employee groups. Section 8 column K is the Rate Set Description, which describes to which employee group the rates tie. Below is an example, using made-up values:

Plan Code	Rate Set Code	Rate Set Description	Note
A	1	Certificated	This might be District 1's certificated employees
A	2	Classified	This might be District 1's classified employees
A	3	Certificated	This might be District 2's certificated
B	4	Certificated	This might be District 1's certificated
C	1	Certificated	Two different plans may have same rates although highly unlikely

Rate Set Code 1: $400 EE, $800 ES, $700 EC, $1,100 EF
Rate Set Code 2: $500 EE, $1,000 ES, $900 EC, $1,400 EF
Etc.

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[12] SD_Code is the district-county code from the OSPI listing of districts at
https://eds.ospi.k12.wa.us/schoollist.aspx

Section 9 — Large Claims — For Plan Years Ending in 2013

For all plans combined, offered to all K–12 districts statewide — list **aggregated** claims **by claimant** with an aggregated total in excess of $100,000 for the plan year ending in 2013. Include claimant status (Employee, Spouse, or Child) and major diagnosis code.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Claim_Amount	Amount in Dollars	Currency
C	Claimant_Status	Indicate Claimant: **E** = Employee, **S** = Spouse, or **C** = Child	Text 1
D	Diagnosis _Code	Numeric value of 1 to 19, from list below	Numeric 1–19
E	PY_Ending	Plan-year-ending date	Date

ICD-9 Major Diagnosis Codes (MDC) — (ICD-9 code ranges) — primary diagnosis code associated with the most services and/or expense:

1	Infectious and Parasitic Diseases (001–139)
2	Neoplasms (140–239)
3	Endocrine, Nutritional, and Metabolic Diseases, and Immunity Disorders (240–279)
4	Diseases of the Blood and Blood-Forming Organs (280–289)
5	Mental Disorders (290–319)
6	Diseases of the Nervous System and Sense Organs (320–389)
7	Diseases of the Circulatory System (390–459)
8	Diseases of the Respiratory System (460–519)
9	Diseases of the Digestive System (520–579)
10	Diseases of the Genitourinary System (580–629)
11	Complications of Pregnancy, Childbirth, and the Puerperium (630–679)
12	Diseases of the Skin and Subcutaneous Tissue (680–709)
13	Diseases of the Musculoskeletal System and Connective Tissue (710–739)
14	Congenital Anomalies (740–759)
15	Certain Conditions Originating in the Perinatal Period (760–779)
16	Symptoms, Signs, and Ill-Defined Conditions (780–799)
17	Injury and Poisoning (800–999)
18	V01–V91 — Supplementary Classification of Factors Influencing Health Status
19	e000–e999 — Supplementary Classification of External Causes of Injury and Poisoning

In future years, ICD-10 codes may be required.

Section 10 — Plan Cost-Share Designs — All Plan Years in 2013

For all plans combined, offered to all K–12 districts statewide — list each unique plan cost-share design.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	CostShare_Code	This is the unique code for the cost-share design, referenced in Section 4 (one or more plans can reference the same cost-share code); there is no standard for the CostShare_Code. It can be a numeric, alpha, or alphanumeric field that represents each unique set of plan benefits. If each plan is different and does not share cost-sharing values with other plans, then each plan will have its own CostShare_Code. You could use "1" for first unique benefit design, "#2" for the second one, and so on. Or you can give them names that represent benefits as long as the code is 20 characters or less in length.	Text 20
C	Ded_Individual_In	Deductible, individual, per calendar year, in-network	Numeric
D	Ded_Individual_Out	Deductible, individual, per calendar year, out-of-network. Enter: **0** (for none), A numeric value (dollars), **-1** if not covered, or **-2** if the out-of-network services are included in the in-network individual deductible	Numeric
E	Ded_Family_In	Deductible, family, per calendar year, in-network	Numeric
F	Ded_Familiy_Out	Deductible, family, per calendar year, out-of-network. Enter: **0** (for none), A numeric value (dollars), **-1** if not covered, or **-2** if the out-of-network services are included in the in-network family deductible	Numeric
G	Coins_Prevent_In	Coinsurance percentage, preventive services, in-network. Enter: **0** (for none), A numeric value between 0 and 100, do not include the "%" sign; or **-1** if not covered	Numeric

Col	Column Name	Column Definition	Format
H	Coins_Prevent_Out	Coinsurance percentage, preventive services, out-of-network. Enter: **0** (for none), A numeric value between 0 and 100, do not include the "%" sign; or **-1** if not covered	Numeric
I	Coins_Other_In	Coinsurance percentage, other services, in-network. Enter a numeric value between 0 and 100. Do not include the "%" sign.	Numeric
J	Coins_Other_Out	Coinsurance percentage, other services, out-of-network. Enter: **0** (for none), A numeric value between 0 and 100, do not include the "%" sign; or **-1** if not covered.	Numeric
K	Copay_Office_In	Copay, office visit, in-network. Enter a numeric amount	Numeric
L	Copay_Office_Out	Copay, office visit, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **-1** if not covered	Numeric

M	Copay_Inpatient_In	Copay, inpatient visit, in-network. Enter:
		0 (for none),
		A numeric dollar amount,
		$ per day, or
		$ per day and the maximum number of copays
			Text 30

N	Copay_Inpatient_Out	Copay, inpatient visit, out-of-network. Enter:
		0 if none,
		$ per day,
		$ per day and the maximum number of copays
		$ per admit, or
		-1 if not covered
			Text 20

O	Copay_Outpatient_In	Copay, outpatient visit, in-network. Enter a numeric amount.	Numeric
P	Copay_Outpatient_Out	Copay, outpatient visit, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **-1** if not covered	Numeric
Q	Copay_ER_In	Copay, ER visit, in-network. Enter a numeric amount.	Numeric
R	Copay_ER_Out	Copay, ER, out-of-network: **0** (for none), A numeric dollar amount, or **-1** if not covered	Numeric
S	OOPM_Individual_In	Out-of-pocket maximum, individual, in-network	Numeric

Col	Column Name	Column Definition	Format
T	OOPM_Individual_Out	Out-of-pocket maximum, individual, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **-2** if included in in-network OOPM	Numeric
U	OOPM_Family_In	Out-of-pocket maximum, family, in-network. Enter a numeric value.	Numeric
V	OOPM_Family_Out	Out-of-pocket maximum, family, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **-2** if included in in-network OOPM	Numeric
W	Rx_Deductible_In	Prescription deductible. Enter: **0** (if none), or A numeric dollar amount per person	Text 20
X	Rx_Retail_CostShare	Retail cost share in three classes — per days' supply shown in column Y: Generic/Brand/Non-Formulary Brand Enter: No coverage, Cost-share $ per prescription per tier, Cost-share % per tier, Minimum or maximum $ cost share per tier Examples: $10/$20/Not covered $10/$20/50% (Max $100) $5/$15/50% (Max $35)	Text 30
Y	Rx_Retail_Days_Supply	Retail days' supply (for example, 30 or 34)	Numeric
Z	Rx_MailOrder_CostShare	Mail-order cost share (same format as Retail)	Text 30
AA	Rx_MailOrder_Days_Supply	Mail Order days' supply (for example: 90)	Numeric
AB	Rx_Specialty_CostShare	Specialty cost share	Text 30
AC	Rx_Specialty_Days_Supply	Specialty days' supply	Numeric
AD	Plan_Comments	Other plan comments/footnotes	Text Memo

Numeric code values for descriptions in numeric fields:

-1 = Not covered

-2 = Included in In-Network (e.g. if in-network deductibles included out-of-network services)

Section 11 — Plan Rates — All Plans Offered in 2013

Table of plan rates — for all plans combined offered to all K–12 districts statewide — list each unique set of plan rates by tier.

Section 8 references plan rates by district. Identify each group of employees with different rates, with their corresponding enrollments by using a reference to a rate-set code corresponding to this table. Any plans/districts/groups with identical rates may reference the same rate set in this table.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Rate_Set_Code	Rate-set code from Section 8	Text 20
C	EE_Rate	Employee-only rate	Currency
D	ES_Rate	Employee and spouse rate	Currency
E	EC_Rate	Employee and child(ren) rate	Currency
F	EF_Rate	Employee, spouse, and child(ren) rate	Currency
G	OD_Rate	Other dependent rate (if used)	Currency